**NORTH CAROLINA DIVISION OF AGING**
**and**
**_____ AREA AGENCY ON AGING**

**MONITORING TOOL FOR INSTITUTIONAL RESPITE CARE**

Community Service Provider: _____
Review Date: _____State Fiscal Year: _____
Interviewer: _____
Person(s) Interviewed and Title: _____

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PROGRAM ADMINISTRATION

Provisions of the Standard

1. Institutional Respite Care services are provided in which of the following locations:

   a. Certified Adult Day/Health Care Facility; Yes__ No__
   b. Licensed Domiciliary Care Facility; Yes__ No__
   c. Licensed Nursing Facility; and/or Yes__ No__
   d. Licensed Hospital. Yes__ No__

   (Page 2 of the Institutional Respite Care Service Standards)

   Documentation verifying compliance: _____
   _____
   Comments: _____
   _____
   _____

2. Clients served are:

   a. Unpaid, primary caregivers who are less than 60 years of age and who are caring for persons who are 60 years of age and older; and/or Yes__ No__
   b. Unpaid, primary caregivers 60 years of age or older who are caring for persons age 18 and over. Yes__ No__

   (Pages 2-3 of the Institutional Respite Care Service Standards)

   Documentation verifying compliance: _____
   _____
   Comments: _____
   _____
   _____

3. Hands on care provided in the absence of the caregiver is provided by an appropriately trained professional or paraprofessional. Yes__ No__
(Page 4 of the Institutional Respite Care Service Standards)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

**SUMMARY OF CLIENT RECORD REVIEW**

For the client record review section, pull a random sample of 5-10% of the active client files, or not less than 10. If less than 10 files, examine all files. Use the attached questions to review each client file. You will need to make a copy of the attached questions for each client file reviewed. After reviewing the client files, complete the questions listed below to summarize client record information.

Of the ____ (number) of client files reviewed,

4. out of the ___ clients needing registration information updated, ___ had completed updates;
5. ___ (number) had a completed screening/intake form;
*6. ___ (number) of clients received a home visit to verify the information obtained during the screening/intake process;
7. ___ (number) of screening/intake forms were signed by the person responsible for completing the form.
8. ___ (number) of client files that contained a service plan indicating the tasks to be provided in the absence of the caregiver;
9. ___ (number) of client files that indicated that the caregiver had been made aware of Client/Patient Rights;
10. ___ (number) of client files that contained a completed Service Cost-Sharing form; and
11. out of ___ (number) clients that needed an annual update of the Service Cost-Sharing form, ___ (number) clients had the Service Cost-Sharing information reviewed with them.

Additional Comments: _____
_____
_____

* A home visit is not required if the agency has a process of ensuring that the facility responsible for Institutional Respite Care services has been determined to have the staff capacity needed to meet the patient's care needs.

Unit Verification

**Verified** source documentation exists that unit(s) reported, and for which reimbursement has been received, were in fact received by the specified person on the date(s) indicated on the Unit of Service Report - DoA ZG901, 902, 903 or comparable document.

Yes__ No__

**SOURCE DOCUMENTATION** for Institutional Respite Care service is the _____, located in _____.

If the DoA ZG901, 902, 903, or comparable document contains 10 or fewer clients reported as receiving a unit(s), **sample all persons and all units.** If 11 or more persons are reported, sample 10% of the persons, or not less than 10, and **all units** reported for each person in the sample.

Attach {as part of work papers} Unit of Service Report used to sample clients and units. **IDENTIFY ON THIS REPORT** the names of the persons sampled and the sampled date(s) on which units were reported as being provided.

Number of UNITS found unverifiable _____

This represents _____% of the total units reported for the month of _____, 199___.

Identify by client the date(s) on which a unit(s) could not be verified;

| **CLIENT NAME** | **DATE(S)** | **UNVERIFIED UNITS** |
|---|---|---|
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Additional Comments: _____
_____

_____ _____
Signature of AAA Administrator/DoA Staff Date

**(Copy and give to provider if Unverifiable Units are found)**

**CLIENT RECORD REVIEW**

**Client Name** _____
**Date** _____
**Interviewer** _____

1. The client registration information was updated every twelve (12) months. Yes__ No__
(Page 5 of the Institutional Respite Care Service Standards)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

2. A screening/intake instrument was completed for the caregiver and addresses the following:

a. Caregiver identifying information; Yes__ No__
b. Ability of patient to perform activities of daily living; Yes__ No__
c. Ability of patient to perform instrumental activities of daily living; Yes__ No__
d. Caregiver's perception of patient's health problems; Yes__ No__
e. Caregiver's perception of patient's well-being (e.g. happy, sad, forgetful, confused); Yes__ No__
f. Extent of caregiver support; and Yes__ No__
g. Services currently being received. Yes__ No__
(Page 3 of the Institutional Respite Care Service Standards)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

3. A home visit was made to the client verifying the information obtained during the screening process or the agency has a process to ensure that the facility responsible for providing Institutional Respite Care services for the patient has the staff capacity needed to meet the patient's care needs. Yes__ No__
(Page 4 of the Institutional Respite Care Service Standards)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

4. The screening/intake form was dated and signed by the person responsible for completing the form. Yes__ No__
(Page 4 of the Institutional Respite Care Service Standards)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

5. A service plan has been completed for the client (person requiring constant care/supervision) and indicates the tasks to be provided in the absence of the caregiver. Yes__ No__
(Page 4 of the Institutional Respite Care Service Standards)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

6. The caregiver has been made aware of Client/ Patient Rights. Yes__ No__
(Page 4 of the Institutional Respite Care Service Standards)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

7. A copy of a completed service cost-sharing form which addresses the purpose of Service Cost-Sharing, the total cost of the service; the agency's procedures for requesting Service Cost-Sharing, and a statement indicating that services will not be terminated for failure to share in the cost of the services received is in the service recipient's file. Yes__ No__
(Page 116 of the Home and Community Care Block Grant Procedures Manual for Community Service Providers)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____

8. A copy of an updated Service Cost-Sharing form exists in the client's file indicating that the following information was reviewed with the

service recipient on an annual basis:

a. the purpose of Service Cost-Sharing; Yes__ No__
b. the total cost of the service; Yes__ No__
c. the agency's procedures for requesting Service Cost-Sharing; and Yes__ No__
d. that services will not be terminated for failure to share in the cost of the services received. Yes__ No__

(Page 113 of the Home and Community Care Block Grant Procedures Manual for Community Service Providers)

Documentation verifying compliance: _____
_____
Comments: _____
_____
_____